Questions and Answers

1915 (b)/(c) Medicaid Waiver
Request for Applications
March 10, 2010

Questions about the RFA

#	Source	Question & Reference	Answer
1	ECBH	**RFA Coversheet**: If there are additional questions related to answers provided by March 10th, will the State accept clarification questions as long as the material is not expanded beyond the responses to the original questions?	No
2	ECBH	**RFA p. 9 Background**: Can the State provide the PMPM for the PBH pilot as well as the fee-for-service costs?	Yes, at some point in the future. The PMPM may vary by geographic area.
3	ECBH	**RFA p. 10 Background**: Can more than one LME be selected for a single county?	No.
4	ECBH	**RFA p. 10 Background**: Do all counties currently covered by an LME need to be included as the proposed catchment area? For example if one county did not supply a letter of support but the number of eligible individuals exceeds 70,000, will the State accept the LME as meeting the minimum requirements?	The RFA requires a letter of support from the full LME board. After the selection process, the LME would be required to get letters of support from all of the counties participating in the geographical region of the waiver entity as proposed in the application. As per the RFA, in the minimum requirement section of the RFA, there is a required minimum Medicaid eligible population to meet.
5	Center Point	**Minimum Requirements:** With regard to covered populations: (1) Are dually eligible individuals included or excluded from the contract? (2) Following the award(s) to selected LME(s), if it currently meets minimum threshold of 70,000 covered individuals, and falls below the threshold due to population shifts or other reasons, will the selected LME be grandfathered in and maintain their contract?	Dual eligibles are included. If a LME is selected, continuation of the DMA and DMHDDSAS contracts when a Medicaid eligible population shifts below 70,000 will be reviewed on a case by case basis and is dependent upon the circumstance that caused the change / decrease in the minimum required population.
6	ECBH	**Minimum Requirements**: If there is one local CFAC member that opposes a waiver and group consensus is required	The RFA requires a letter of support from the CFAC of the LME applying. If the local CFAC policy requires full

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		in order for a letter of support for multi-county jurisdiction, please provide guidance on how to address this situation in response to the RFA. Will a lack of CFAC support letter disqualify the LME?	support prior to writing such a letter, we will accept, as part of the application process, a letter from the CFAC chair indicating the number that support participation in the waiver and the number that do not with an explanation of the local CFAC policy.
7	ECBH	**Minimum Requirements**: Must all counties provide a letter of support as part of the application?	The RFA requires a letter of support from the full board. If selected, the LME would be requested to get letters of support from each county participating in the geographical region of the waiver entity.
8	ECBH	**Minimum Requirements** p. 13: The application requires letters of support from counties in the coverage area. Difficulties are being encountered with obtaining letters within the 2 month period. If an application is submitted but not all the county letters of support are turned available, will that render the application incomplete? Can the State extend the deadline for submitting the letters of support?	The RFA requires a letter of support from the full LME board. After the selection process, the LME would be required to get letters of support from all of the counties participating in the geographical region of the waiver entity as proposed in the application.
9	ECBH	**Minimum Requirements** p. 12: If an LME has URAC accreditation without the credentialing piece, will they be allowed to wait until the next three year renewal?	Yes.
10	Western Highlands	**Minimum Requirements Checklist**: What is intended to go in the "Location" column? Page # reference in the application? Or physical location in/at the LME?	See instruction in RFA, page 27. The Location refers to where it is in the LME's submitted application.
11	Sandhills	**Minimum Requirements**: p.13 – "The decision to undertake the operation of a PIHP….must be made with the agreement and support of an LME's Board and local CFAC**,** <u>as well as the support of each county included in the LME's catchment area.</u>" How is this demonstrated in an existing multicounty LME?	All counties are represented on the LME Board and the letter from the Board is sufficient for the application. After selection, each county must provide a letter of support.

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12	Sandhills	**Minimum Requirements**: p. 13 – "…must submit as part of its application all subcontracts in sufficient detail to demonstrate how the subcontracted function(s) will operate and be managed by the LME." Does this include the current functions currently being contracted / delegated by the LME (i.e. STR after-hours)?	Yes, ALL subcontracts.
13	Sandhills	**Minimum Requirements**: p. 13 – "basic guidelines and requirements such as credentialing, utilization management, data management, reporting, performance measures, and other key functions"…. "Following selection and announcement of new LMEs…DMA, DMH, PBH and new LME will collaborate to develop basic statewide guidelines and requirements." How does this relate to submission of current processes?	There are minimum federal requirements and contractual Medicaid requirements that are not negotiable. The LME submits proposed operations and an implementation plan for the transition from current practices. If a submitted proposal is selected and announced and there are needed changes to the submitted proposal, the selected partners will collaborate to develop basic statewide guidelines and requirements
14	Sandhills	**Minimum Requirements Checklist**: #5 What is an adequate fund balance reserve?	The LME has an adequate fund balance reserve on hand, as per State policy requirements, without the fund balance reserve by being negatively impacted by attempting to transition into meeting the requirement needs of the RFA and both the DMA and DMHDDSAS Contracts.
15	Sandhills	**Minimum Requirements Checklist**: Is there a format of the Letter of Support from full LME Board assuming financial responsibility in submitting the application?	No
16	Sandhills	**Minimum Requirements Checklist** #10 Is one letter of support from the CFAC, signed by the Chair adequate?	Yes
17	ECBH	**Finance**: Will DMH reduce the current LME systems management allocation to an LME if they are awarded the DMA waiver management contract?	Participating waiver entities will no longer receive a separate LME Systems Management Payment. The capitation from Medicaid will include "administrative" type cost. Similarly, the state funds currently supporting LME Systems Management payments will be added to the Waiver entities Single Stream Payment. Both the DMA and

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			DMH/DD/SAS contracts referenced have a % limitation on the Medicaid and State funds that may be used for administrative and management purposes. If 2 or 3 LMEs come together in arrangement that is less than a full merger, none of the participating LMEs will receive separate LME Systems Management Payments. The Waiver LME will receive the State and Medicaid funds and all participating LMEs must operate within the administration limits. It will be up to the participating LMEs to decide among themselves how the administrative/management funds are allocated.
18	Western Highlands	**Finance**: A LME currently receives $5 M in systems management funds (say that's 15% of IPRS funding). Will this amount be added to the 9.5% that is allowed under Medicaid? Or would the $5M be reduced to whatever 9.5% would be?	See response to question 17 above.
19	Sandhills	**Finance**: p.11 – "The State will request approval from CMS to add an additional 2% to the monthly capitation payment to begin funding the risk reserve account." Has this been submitted? Approved?	No. The request will be made when the capitated payments are submitted to CMS for approval. This was the same arrangement with Piedmont and CMS did approve. We do not expect a different response at this time.
20	Mecklenburg	**Finance**: p. 28 Would an integrated single county financial audit meet the requirements for annual audit to be submitted with the application?	Yes
21	ECBH	**Finance**: How many copies of the audit are required?	RFA requires three copies.
22	Mecklenburg	**Finance**: p. 24 To whom are the certified final reports sent to?	DHHS. This will be discussed in more detail with LME(s) chosen after the selection is made.
23	Mecklenburg	**Encounter Data and Claims**: p.24 What is the time frame for OMMIS?	Anticipated implementation date is August 2011.
24	Sandhills	**Finance**: Are 3 copies of all financial statements by an independent CPA due on April 14? If so that is tough during tax season.	We will revise the reference to audited financial statements. The three most recent financial statements must be prepared in accordance with Generally

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			Accepted Accounting Principles but do not have to be completed by a CPA.
25	Five County	**Finance**: Will system management funds be reduced should 3 LMEs partner but not merge given that one entity will receive the funds for all? Are the total combined funds reduced? If so, how will the reductions be determined?	See response to question 17.
26	Mecklenburg	**Finance**: Please elaborate on the cost reporting requirements. How can we set ourselves up to respond to cost reporting requirements that are now combined?	This will be discussed in detail with the selected LME(s).
27	Western Highlands	**Finance**: Are we held accountable for what is spent between Medicaid and State dollars for a staff member's time? Staff mapping between Medicaid and State funding: How much accounting should take place for time paid for by these funds?	This is an MIS / financial accounting business practice of revenue and of expenditures and the accountability of Medicaid and state dollars between administrative and services. It is not expected to translate into splitting the waiver entity management responsibilities of management / staff role function and responsibilities. It is the expectation of the waiver entity to carry out the functions and responsibilities of both contracts as one waiver entity. CMS has required the ability to show staffing time for Medicaid and non-Medicaid activities.
28	ECBH	**Finance**: When will the rate setting for PMPM occur?	Once the LME(s) is (are) chosen, actuarial studies for the specific geographic areas will be completed. Once those are finalized, the PMPM will be set.
29	Mecklenburg	**Finance**: What is the re-negotiation period for per month per member payments, i.e. will this apply to end of contract cycle or sooner if needed? Need clarification of the financial implications of utilization management incentives for pharmacy costs as well as clarification regarding ER charges for all pharmacy, psychiatrist services and ER charges for consumers with primary behavioral health diagnosis.	Medicaid per member per month payments are calculated annually. In rare situations, Medicaid may recalculate rates due to extenuating circumstances such as significant increases in population or change in benefit package. The LME will be responsible for all emergency room charges with a primary diagnosis of MH/DD/SAS. All psychiatrist services, including but not limited to evaluation and management

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		Is subcontractor equivalent to a delegate as defined by URAC or NCQA?	services provided by psychiatrists, are included in the capitation and are the responsibility of the LME. Yes.
30	Center Point	**Finance**: When will a data book be available that includes member months by eligibility cell; services & utilization by eligibility cell; assumptions based on historical costs for services?	This is part of the rate-setting process for individual LMEs that have been approved for participation in the waiver and will occur after selection(s) have been made.
31	Center Point	**Finance**: What adjustments will be made for historical costs such as CSS coverage that will not longer be included in the benefit plan?	Rate calculations take into account historical utilization, trends and program changes, including the impact of terminated services on the utilization of other services. Anticipated services as a result of changes are also factored in. Audited results, such as numbers of people not needing the service are also factored in. Calculations include valid costs, not costs that were subject to payback.
32	Center Point	**Finance**: Since the goal is more enhanced services and less inpatient, what assumptions will be used in the capitation calculation to support that develop and system transition?	See response to question 31.
33	Center Point	**Finance**: What is the level of responsibility for 3rd party?	See section 10.7 of the DMA contract.
34	LME Source Unknown	**Finance**: Can you adjust your Medicaid rates for Medicaid services and do the IPRS rates have to match those?	The LME negotiates Medicaid payment rates with providers within the parameters set by DHHS. The LME may not pay less in state funds for a Medicaid covered service than they pay in Medicaid funds.
35	Center Point	**Information Services**: Describe recovery site IS requirements.	As part of the RFA application the waiver entity is required to have policies and procedures in place describing the Recovery Site IS requirements and process. General guidance may be obtained from ITS or CMS website.
36	Sandhills	**Staffing**: p. 22 5th bullet from the top - "For each position, attach a current resume…" Is that a resume for every staff member or just those positions listed in the bullets above?	Just those listed in the bullets above.

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37	ECBH	**Staffing**: Can one individual staff member handle both State and Medicaid aspects of a function?	Yes.
38	ECBH	**Staffing**: Can an RN fill the role of the Clinical Director for services of the RFA?	Must be an advanced psychiatric nurse practitioner.
39	ECBH	**Staffing**: The RFA under Facilities and Organization specifies a full-time contract manager but does not reference clinical licensure requirements.	The Contract Manager position does not require clinical licensure.
40	Center Point	**Provider Network Management**: How do you determine provider capacity?	Provider capacity refers to the capacity of the LME's network to meet consumers' service needs within the access and availability requirements specified in the contracts.
41	ECBH	**Provider Network**: What is the transition process from an open to a closed network? Can we start fresh with a brand new network?	The RFA requires for the LME to describe the transition process from an open provider network to a closed provider network. The provider contracts for a PIHP are different; therefore, the LME will have to enter into new provider contracts for each provider in the closed network, which would require an engagement of all providers in the process.
42	ECBH	**Provider Network**: p. 19 Would the LME be able to require a standardized assessment?	Yes, the LME has the right to design the provider network, including a description of the assessment process proposed.
43	LME Source Unknown	**Enrollment data & UM**: If no currently enrollment and eligibility data, what would need to be submitted?	Not enough information regarding the question has been provided to answer it. However, all Medicaid eligibility data and utilization data is available to every LME by county.
44	Sandhills	**Quality Assurance and Quality Management**: p. 17 • CMS Quality Framework Model (page 17) – define this • Licensure/Experience Issues – QA/QM/Grievance System Staffing (page 18) can CQAP/CQMP certification be substituted?	This refers to the federal Centers for Medicare and Medicaid (CMS) Quality Framework developed for 1915 (c) waivers that can be accessed on the CMS website at: http://www.hcbs.org/files/28/1377/QFramework.pdf Refer to the staff qualifications in section 6.9 of the scope of work of the DMA contract.

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45	Sandhills	**Provider Network**: • p. 19 Provider Network Management – Bullet # 7: "Provide a listing of fully executed contracted providers by level of care and by zip code." In this context what is meant by "level of care"? • p. 20 – Bullet # 5: "Describe the transition process from an open provider network…to a closed Provider Network…" What elements should be included / covered in the RFA submission for the transition process? • p. 20 care plan transitions: What is meant by this?	The RFA requires the LME to describe a network management program that supports the needs of all enrollees and individuals of Medicaid and state funded services this is one bullet as a means to help fulfill that purpose of this section in identifying the range of services being offered by the provider network. The RFA requires the LME to describe the transition process from an open provider network to a closed provider network. The provider contracts for a PIHP are different; therefore, the LME will have to enter into new provider contracts for each provider in the closed network which would require an engagement of all providers in the process. The RFA requires the LME to describe the transition process from an open provider network to a closed provider network, describing what is the Care Transition plan process for consumers who are receiving services impacted by this activity.
46	Sandhills	**Facilities and Organization**: p. 21 • p. 22, Administrative Operations – Bullet # 3: "One full time provider network director that is a licensed clinician that has at least 5 years combined clinical, network operations, provide relations and management experience." Is there any allowance for non-licensed staff to serve in the role of provider network director?	No.
47	Sandhills	**Encounter Data and Claims**: • p. 23, Is encounter data forwarded to DMA using our current 837 transaction file? Or is this a different electronic file for reporting only to DMA? • p. 23, Could you elaborate on what submission reports generated for	The 837 transaction file is the standard file for submission of claims. It can also be used to submit shadow claims. The DMA side of MMIS+ cannot currently handle shadow claims (zero pay) like the IPRS side can. However, the new MMIS, which is scheduled for implementation in the fall of 2011, will

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		encountered submission process would be for DMA?	have this capability. Until the new MMIS is functioning, the selected LME will submit Medicaid data in the same manner as Piedmont. At that time, the LME will be expected to submit shadow claims retroactive back to the date the LME started participating in the waiver. A report template should be submitted to document the validation process to ensure that the number of encounters/claims received was actually received and nothing was lost during the transmission process.
48	Mecklenburg	**Financial Reporting requirements**: p. 24 "Process for certifying financial records submitted as reports": Submitted to whom? What records and reports?	This refers to the financial reporting requirements defined in the DMA contract.
49	Sandhills	**Financial Management/Monitoring**: • p. 25 - Can you use cost centers to provide separately expenses and revenues for Title XIX Medicaid from other funding sources • p. 25 - Is the provider responsible for coordination of benefits?	Yes. The LME should propose in its response how coordination of benefits will be addressed.
50	Sandhills	**Contractor Designated as a Single PIHP**: • p.25 - Do the sections on stakeholder engagement and collaborative partnerships only apply to non single LMEs?	No. Stakeholder engagement and collaboration are important to all LMEs.
51	Sandhills	**Financial Status and Viability**: • p. 28 – Please explain reports and statements from bullet #2 on what the independent CPA would be doing and what time period would this cover. • Is there a cost model of positions compared to recipient enrollment?	See the response to question 24. No
52		**Clinical Operations, Customer Service**: p. 15 • "Describe how enrollees are educated about benefits and services and provide a sample of educational materials.	Applicants should detail their plan for educating enrollees about benefits and services; application should detail all

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		Include any evidence of education for enrollees on emergency services." Are they asking about any and all of the different ways enrollees are educated about services? Are they asking for samples of each? Do they care about how people who are not yet enrollees are educated about services? • "Because enrollment in the LME is mandatory, the LME shall not be required to comply with CMS's marketing regulations." Does this mean we may market however we see fit, to whomever we like, as we see a need, as long as it falls within our means? Need clarification on this.	methods and include samples as applicable. Applicants should address current ineligibles if part of the LME's education plan. Marketing is not applicable as there will be only one PIHP per geographic area and enrollment in the single PIHP is mandatory.
53		**Care Management/Utilization Management**: p. 16 Please clarify "process for assisting enrollees choosing consumer directed care available under the Innovations waiver program"	Describe how the LME will inform Innovations participants about the consumer directed option, and if the consumer selects this option, describe how the LME will support the consumer in directing his or her services and supports.
54	Mecklenburg	**Provider Network Management**: p.19 • Need clarification on 'Provide evidence that staff is representative of the population's ethnic and racial makeup according to the latest US Census Bureau data.' • Does this mean ethnic diversity of provider staff =ethnic diversity of population	Yes
55	Pathways	**Provider Network Management**: What is the expectation for interaction and monitoring of MDs (like general practice) who will bill psychiatric codes? What is the expected authorization / management of psychiatric codes by these MDs?	The LME is responsible for authorizing and monitoring all Medicaid psychiatric procedure codes regardless of whether they are billed by a general practice MD, psychiatrist or other practitioner.
56	Mecklenburg	**Administrative Operations Encounter Data and Claims**: p. 23 • The limit is 3 pages for this section. Is this exclusive of the policies and procedures, flow charts and copies of reports requested in this section?	Yes

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		• 2nd bullet – Support documentation for creating and transmitting encounter data to DMA. What kind of documentation – 837 setup information or actual copies of sample transmissions? • 3rd bullet – References "errors" found during encounter claim processing. Does error refer to "denials" as used here? • 7th bullet – Internal controls regarding fraud and abuse. Is this specific to claims only in this section or is this broader than claims? • If there is savings in the administrative functions, can it be set aside in a reserve or restricted account? • Since there are no start up dollars available could future savings on the administrative portion of the cap be used to pay Mecklenburg County back for "loaning" the LME start up funding? • Does the admin portion of the cap have to be accounted completely separate in the same way as the service dollars? • Currently the LME is responsible for processing purchase orders and ordering items related to the CAP waiver. Under this waiver can this responsibility be shifted to case management providers with the LME reimbursing the provider after the fact?	The LME should have a documented process for creating and transmitting their data encounter transaction file that complies with the policy and procedures defined by the State. No, errors. This reference to fraud and abuse is specific to claims only. Savings in the Medicaid capitation may be set aside in a reserve or restricted account or used for any other purpose at the discretion of the LME. The LME may provide these items directly or through contract with other providers. Yes. The LME may provide these items directly or through contract with other providers.
57	Sandhills	**Application Face Sheet**: Service Delivery Site(s) – what is this referring to?	This is a standard DHHS form. However, the request for Service Delivery Site(s) is not applicable to this RFA. Do no complete this line.
58	ECBH	**Site Review**: Regarding the on site reviews, how many people will visit and for what length of time? Will you send a checklist in advance?	Approximately 12 people. The RFA states that "The Evaluation Committee will conduct a desk review of each application and recommend one or more LME(s) as finalist whose application is deemed to be in the best interest of the State". The duration of the site visit will be dependent upon items needing to be reviewed at the time of the site visit. No checklist will be

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			provided.
59	ECBH	**Selection Process**: How will the State select the LME(s) for participation in the waiver?	The selection will be based on the Evaluations of Applications section of the RFA. Final scoring will include the findings of the site visit and desk review. The Evaluation Committee will make final recommendations to the DHHS Leadership for final selection. All selection materials are subject to CMS review and audit.
60	ECBH	**C Waiver**: What is the difference between the Innovations waiver and the CAP-MR/DD waiver? Why didn't the State adopt the CAP waiver?	There are several differences, including but not limited to, different services and service definitions, inclusion of a resource allocation methodology in the Innovations waiver and changes in performance measures and the quality strategy; most of them are minor and, it should be noted that some changes were made to the Innovations waiver to incorporate certain elements of the CAP waiver. The State chose to use the Innovations framework because it was logistically easier to amend the Innovations waiver than to "start from scratch."
61	ECBH	**Services**: What is the status of an LME's unique services approved prior to applying for the waiver?	The LME must have all State Plan and B(3) services available according to access regulations. State (DMHDDSAS) Services unique to the LME may be only those that are state funded and approved through the existing alternative service definition process as per DMHDDSAS policy. A LME selected may need these services to be reviewed to eliminate any overlap of duplication of State Plan and/or B(3).
62	Western Highlands	**Services, section 6.5**: p. 20 Describe how the LME will address access for individuals who require services when they are outside the LME's catchment area (e.g., while traveling in North Carolina or when residing in a group home outside the LME's catchment area). Please discuss expectations in more depth.	The LME is responsible for the Medicaid enrollees of its catchment area and must define in the application how it will ensure service provision and payment when enrollees must receive treatment out of the LME's service area.

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63	Center Point	**Services**: With Regard to covered services: (1) What new services will be pursued under the (b) 3 reinvestment option? For readying a provider network, will these be identified before implementation or added after implementation? (2) Will state hospital inpatient funds (non-Medicaid) be part of the capitation or otherwise allocated to the selected LME(s)?	New 1915(b)(3) services have not been discussed as of this date; any new 1915(b)(3) services would be added after implementation. That section is addressed in the DMHDDSAS contract, Attachment III, Financing section 2.2. Also as note COMMENT: Footnote To Potential LME Waiver Entity financing sections subject to change based upon several variables.
64	ECBH	**Staffing**: Is a Human Services Degree required for the QA Director? Can we grandfather in staff with adequate experience that does not have degrees? Conflict between: DMA Contract 6.9 K: Human services degree: BA or MA required. RFA p. 22 states at least 4 years recent QM experience & 2 years managed care experience or experience in MH/DD/SAS.	A Human Services bachelors or masters degree is required along with required work experience. Licensure is not necessary for the QA Director. There is no grandfathering.

Questions about the DMA Draft Contract

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65	ECBH	**Staffing**: What are the provisions for nurses (RN) to be utilized in any of these roles and what are the level of degree and experience required? Must an RN have a BA or MA?	This question cannot be answered without having more detail to the function and/or the position being referred to within the RFA or the Contracts.
66	Mecklenburg	**Staffing**: Please clarify conflict between the RFA and DMA Contract Attachment G, p. 20 6.9: Contract manager with 7 years with or without a license?	Licensure is not required for this position.
67	Mecklenburg	**Staffing**: What is the rationale for the Provider Relations person to be	The provider relations director is responsible for helping to shape the

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		licensed?	provider network. Clinical skills are required for that task. In addition, we would expect the Provider Relations Director to have significant interaction with licensed provider management staff and must be able to communicate on a peer level.
68	ECBH	**Finance** p. 11 Scope of Work: Will the funding source and contract for an existing LME remain or will the current responsibilities be combined with the expanded waiver responsibilities and covered under one single payment and contract?	There will be two contracts, one for each funding source. The LME will be responsible for the scope of work covered in each contract. See response to question 9 for additional detail on administrative funding.
69	ECBH	**Provider Network**: p. 19 As a waiver entity can the LME limit all networks? For example, does it control the size of the directly enrolled independent practitioners and inpatient hospitals the same as it will enhanced or endorsed provider networks? If so, will existing providers be grandfathered in or will the LME waiver site have the ability to eliminate providers from the start of the waiver?	All providers must enroll in the PIHP if they wish to provide services to enrollees in that geographic area. There is no grandfathering. A new contract is developed with each provider.
70	ECBH	**Provider Network**: p. 19 Will the LME awarded the waiver have the ability to make its own decisions about network, size, scope, capacity or will there be a statewide formula?	The LME makes decision about the provider network addressing the parameters identified within the RFA and the DMA and DMHDDSAS contracts. The RFA states that following the selection process and the announcement of the next LME(s) to participate in the waiver expansion process, the new entity will work with DMA, DMH/DD/SAS and PBH to collaborate and develop basic state wide guidelines and requirements.
71	ECBH	**Provider Network**: p. 19 Can a waiver entity decide whether or not to purchase services using fee for service, case rate, capitation or other models in addition to rate setting?	Yes, within limits and with further guidance from the State as identified above.
72	ECBH	**Services**: p. 19 Will the LME be able to purchase services under the waiver that are unique to an area? For example, if a	A LME applying as a waiver entity would be expected to follow State policy unless otherwise indicated.

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		school based MH clinic for children makes more sense in a rural area that does not have the population to support a child continuum currently required under a CABHA can the waiver LME purchase School Based MH Clinic instead? If so, could the LME have that clinic perform case management services for the specialized MH/SA/DD population under such a mole since these models typically include med management and outpatient treatment services and case management but not day treatment and IIH types of services?	MH/SA case management may be provided by only a certified CABHA provider as per State CABHA policy. The LME may contract with a case management provider whose certified CABHA site is either inside or outside of the LME's catchment area for case management services. The location of those services is up to the provider agency as long as the regulations for access are met. See answer to question 12 also.
73	ECBH	**Services**: p. 19 In areas that are rural where co-location with health depts. And social services are more culturally competent and appropriate would an LME be allowed to purchase packages of services for adults from such vendors to consolidate cost but meet recipient needs? For example, operating groups for MH and SA out of health department using other Health Educators who may not currently be eligible under existing 10NCAC 27.G .0104 standards? Or providing peer support groups when the agency is not a CBAHA? Or will the waiver sites also have the same requirements for CABHA in the rural areas?	Rule and the SPA are the authority. Any requests for exceptions must be built into the waiver application.
74	ECBH	**Services**: p. 20 Appointment Availability (bullet #2): Please confirm that eligibility in this context refers to meeting requirements for service and not eligibility for Medicaid enrollment. If this is incorrect, please clarify.	Yes. This refers to meeting eligibility requirements for behavioral health services.
75	ECBH	**Provider Network**: p. 20 Clinical Operations: The section states "Describe the transition process from an open provider network under the current Medicaid and DMHDDSAS funded system to a closed Provider Network and issuing new provider contracts with the current DMA	No. The LME cannot limit its provider network until the DMA and the DMH/DD/SAS contracts are signed and would be effective at the start date of the contracts. The LME selected as a waiver entity must keep their existing provider contracts with current

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		provider…." Will the waiver LME start out with the current DMA provider network? Does the entire network need to be contracted during the six month implementation period? Do any providers who do not meet the defined LME criteria for the network go through the established hearing process? Or may the LME choose who to contract with based on a set of approved and established criteria for being in the network?	providers until the effective start date of contracts with the State. However, the LME must have in place the new provider contracts signed to become effective for the start date of the waiver entity. The LME may choose with whom they contract. See the DMA contract for provider appeal rights. This is not the current appeal process.
76	ECBH	**Provider Network**: Will the state adopt treatment protocols and levels of care to improve statewide consistency with authorization practices between PBH and the other LMEs who may be awarded the waiver prior to the implementation of the waiver.	Refer to RFA last paragraph at the bottom of page 13.
77	ECBH	**Finance**: When will the capitation amount be disclosed?	After the waiver entity selection is made, announced and actuarial calculations are completed. The Medicaid population based upon eligibility categories and the other factors mentioned above, determine the capitation rate.
78	ECBH	**Care Coordination**: Will the waiver LME have to do the care coordination like PBH under the 1915C for developmental disabilities or can it be delegated to an agency like The Arc?	The LME is responsible for proposing to the State, in the submitted application, how it will carry out the required functions described within the RFA and both the DMA & DMHDDSAS contracts. The RFA states the LME may propose to subcontract out one or more functions. The applying LME is responsible for all waiver management functions and any sub-contracted functions, describing how sub-contracted functions will operate and managed by the LME
79	ECBH	**Services**: Will waiver sites be required to have a local presence in every county like the PBH face to face outreach program or can this be done with mobile crisis management (MCM) service?	The LME is responsible for proposing to the State, in the submitted application, as to how it will carry out the required functions described within the RFA and both the DMA & DMHDDSAS contracts. The LME

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			must meet access requirements as outlined in the DMA and DMHDDSAS contracts.
80	ECBH	**Services**: Will the PBH treatment algorithms by diagnosis be able to be implemented across waiver sites?	As stated above, the LME is responsible for proposing to the State, in the submitted application, as to how it will carry out the required functions described within the RFA and both the DMA / DMHDDSAS contracts. If this is the LME's intent it should be reflected in the RFA application. Also, subject to the last paragraph on page 13 of the RFA.
81	ECBH	**Staffing**: Will the state allow QPs to deliver the SIS within the waiver sites rather than requiring that it be administered by licensed professionals?	No. At this time a licensed professional must administer the SIS.
82	ECBH	**Appeals**: Explain the difference between the appeal process in the waiver site and the current appeal process under ValueOptions.	A LME conducts a local hearing as the first step in the appeal process. After the local hearing, the enrollee may access the State fair hearing process which included OAH and final agency decision by DMA.
83	ECBH	**DMA contract, Attachment B, SOW 1.8 Conflict of Interest**: RFA States, "No official or employee of the LME shall acquire any personal interest, direct or indirect, in any provider network." Please define indirect interest.	An indirect interest generally involves the interest of a third party related by blood, such as a brother, sister or mother that comes into conflict. A situation could arise involving a financial interest of that third party. No LME employee may have direct or indirect interest in services operated under the auspices of this waiver. If family members receive direct service under the waiver, safequards must be in place that demonstrate no personal gain or involvement in the decision making process of authorization or due process.
84	ECBH	**DMA contract, Attachment B, SOW 1.9 Risk Reserve**: If the earnings of risk reserve increase the reserve over 15%, can the excess be withdrawn as long as permission is requested and granted from the State?	Yes, subject to the requirements in Section 1.9b of the DMA contract.

#	Source	Question & Reference	Answer
85	ECBH	**DMA contract, Attachment B, SOW, 6.9 Facilities and Resources**: Staff qualifications required at a minimum Master's Level Behavioral Health professions. This excludes individuals who have a bachelor's degree and are licensed clinical social workers (LCSW). Will the State accept an LCSW with a Bachelor's degree?	No
86	ECBH	**DMA contract, Attachment B, SOW, 7.3 Inspection and Monitoring**: Please define the enrollment practice of the LME that is to be monitored. Will the LME be approving enrollment in the Innovations waiver? If so, please provide additional information regarding the requirements of enrollment.	Enrollment practices of the LME to be monitored include provision of BH education services, referenced in 6.14 of the Scope of Work (SOW) and 6.15 "Policies & Procedures Regarding Enrollee Rights." The LME will be approving enrollment in the Innovations waiver, based on slot allotment and the requirements of the Innovations waiver.
87	ECBH	**DMA contract, Attachment B, SOW, 7.4 Practice Guidelines**: Does the Medical Director need to approve all inpatient and intermediate care authorizations?	These must be approved by a physician or a physician's assistant (PA).
88	ECBH	**DMA contract, Attachment B, SOW, 7.4, Notice of termination, Suspension, or Reduction of Services**: please confirm that the language of "previously authorized Medicaid-covered services" does not apply to inpatient unless services are authorized in advance but find the medical necessity was not met.	This refers to all Medicaid-reimbursable services.
89	ECBH	**DMA contract, Attachment B, SOW, 9.2 Encounter Data**: What is the estimated timeline for when MMIS will be revised to accept and process encounter data?	Anticipated: August 2011.
90	ECBH	**DMA contract, Attachment B, SOW, 11.1 Subcontract Requirements**: The section appears to be focused on subcontracts with providers (section 1.). Do the provisions also apply to non-provider subcontracts?	Yes.

#	Source	Question & Reference	Answer
91	ECBH	**DMA contract, Attachment B, SOW, 12.1 LME Breach—Remedies**: Please define what constitutes a breach of contract. Does the ability to impose sanctions without the opportunity to cure apply only to a material/major breach?	Any violation of the contract. Yes.
92	ECBH	**DMA contract, Attachment J**: Please provide the current rate cells for capitated payments to the PBH pilot.	There are six rate cells: • TANF, MIC, MPW, MAF • Children in foster care • Blind/disabled under age 21 • Blind/disabled over age 21 • Elderly • Innovations participants
93	ECBH	**DMA contract, Attachment M, G.1 Health and Safety**: Regarding Critical Incident Reports, please define, "LME intervention." Currently all critical incident reports are reported to the LME by providers, but many do not need LME intervention.	Current State policies must be followed regarding Critical Incident Reports.
94	ECBH	**DMA contract, Attachment T, Accessibility D**: Requirements states that new enrollee orientation materials are to be sent within 14 days of enrollment. Attachment B, Section 6.10 states that the DMA will send these materials. Attachment B, Section 6.11 states the LME will send information to a new enrollee upon request for services. These statements appear to be contradictory. Please clarify the requirements of the LME.	6.10: This is general information that DMA sends to every enrollee when they become eligible for Medicaid and are in a PIHP area. In 6.11, this is the information that an LME must send when an individual requests MHDDSAS services from a PIHP.
95	Western Highlands	**DMA contract, Finance**: At what point in the waiver contracting process will LMEs know what their PMPM rates will be?	Within several months of selection. See response to question 28.
96	Western Highlands	**DMA contract, Finance**: We do not see the administrative percentage in the DMA contract, how will that be documented?	See response to question 17.
97	Western Highlands	**DMA contract, Restricted Risk Reserve**: Need clarification regarding apparent difference between the RFA	The State will request approval from CMS to add an additional 2% to the monthly capitated payment to be paid to

#	Source	Question & Reference	Answer
		and the DMA Contract. The DMA Contract (p. 9 – 1.9a Restricted Reserve Account) says that 2% will be withheld from the monthly capitated (PMPM) received by LMEs for a risk reserve account. The RFA (p.11 – 2nd paragraph from the bottom) appears to say that the state will request to add an additional 2% to begin funding risk reserve account. Please clarify?	the LME. The LME will deposit the 2% of the monthly capitated payment in the risk reserve account until the risk reserve account equals 15% of the annualized capitated payment.
98	Western Highlands	**DMA contract, p. 13 – 3.1 Persons Eligible for Enrollment**: Can we assume that all member information for CAP/DA, CAP/AIDS, Adult Care Home Residents will be included in the routinely-provided file(s) referenced p.32 Section 7.9?	Yes, minus CAP/AIDS. This program has been terminated.
99	Western Highlands	**DMA contract, p.13 - 3.2 Persons Ineligible**: Medicare Qualified Beneficiaries (MQB) are ineligible – are dual eligibles (Medicare/Medicaid) considered primary Medicaid therefore covered under the waiver?	Dual eligibles are covered under the waiver. Medicare is primary but they are enrolled in the PIHP.
100	Western Highlands	**DMA contract, p.13 - 4.1 Plan Enrollment**: Is enrollment "automatic"? What is meant by "…subject to enrollment"? What are the datasets required for enrollment? (STR, Registration, etc.)	All Medicaid recipients are automatically enrolled in the LME's PIHP at the time the Medicaid application is approved.
101	Western Highlands	**DMA contract, p. 14 – 4.6 Automatic Disenrollment-(e):** "a Medicaid eligible is admitted to an IMD and is between the ages of 22 – 64…" – will the LME not be assessed for the stay in any IMD when the eligible person is now considered ineligible? E.g., state hospitals (IMD) – LME only pays for children, adolescents and geriatric consumers?	When an adult (aged 22-64) enters an IMD, the LME cannot pay for the IMD service with Medicaid dollars. Assuming that the state funds associated with the LME's historic use of the state hospitals is included in the LMEs Single Stream Funding, as is currently the case for PBH, the LME will be responsible for using State dollars to cover the cost of a state hospital admission of individuals aged 22-64.
102	Western Highlands	**DMA contract, p. 15 – Section 6.1 – Duties of the LME**: Please define "Claims Fund". Is it simply a reserve fund set aside to cover Medicaid claims	The claims fund is what is left over after paying all claims incurred during the previous fiscal year.

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		payable at the end of the fiscal year, and estimated claims incurred but not reported (IBNR)?	
103	Western Highlands	**DMA contract, p. 19 - 6.9 Facilities & Resources**: UM managers and care managers – minimum of Master's in BH, licensed and 2 years experience – is this all of the Utilization Mgmt/Care Mgmt staff, or just supervisory staff; does the term "manager" refer to the "supervising manager" or is this a generic term as in "Care Manager"? Are peer-support specialists eligible to provide LME Care Management? What about QDDPs?	All UM staff that authorize services. Peer support specialists and QDDPs do not meet these qualifications.
104	Western Highlands	**DMA contract, p. 22 – 6.13–Care Management-(b):** "Special health care needs" populations – are these the Quadrant 4 (high behavioral and physical health needs -- integrated care model) customers and what are the expectations beyond the behavioral health care needs for support/treatment and coordinated care management?	On p. 22 the DMA contract outlines six special health care needs populations. Section 6.13 c-l lists all functions that the PIHP must perform for these populations, including developing a treatment plan/person centered plan if indicated.
105	Western Highlands	**DMA contract, p.22 – 6.13-Care Management-(d):** says the LME "shall produce a treatment plan" – exactly what does this mean – LMEs do assessments and develop treatment (PCP?) plans? Does this contradict the "divested of services" status of LMEs in a waiver? It does say "approved" below but the term "shall produce a treatment plan" needs clarity. Sounds more like an 'integrated care management plan'.	The treatment plan is literally the person centered plan (PCP). The LME is responsible for describing in the application how this will be performed.
106	LME Source Unknown	**DMA contract, p. 22 Section 6.13**: The section indicates that an LME shall produce a treatment plan for all populations. Can this function be contracted out? It parallels case management.	The LME is responsible for Care Management function but may provide it directly or through sub-contracting as identified in the RFA. Case management and care management are not the same function.
107	Sandhills	**DMA contract, Attachment B, 6.13, p. 22**: Is care management able to be contracted?	Yes.

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108	Western Highlands	**DMA contract, p. 29 - 7.4 Utilization Plan – Practice Guidelines – 3rd paragraph**: "inpatient and immediate care in an institution shall be approved by a physician or physician's assistant as required by 42CFR Part 456"- this sentence seems to contradict the sentence above that indicates that these services can be authorized by behavioral health professionals. – Please clarify?	The behavioral health professional must review the request, but the physician or PA must approve the request.
109	Western Highlands	**DMA contract, p.33 - 7.9 Health Information System-(f):** Inbound claims - What are expectations around receiving/processing paper claims? Can we assume that electronic submission will be the norm, and that paper claims will only be for exceptions (e.g. coordination of benefits?)	The LME defines the requirements for claims submission. It is likely that most claims will be submitted electronically, but the LME may need the capability to accept paper claims in certain situations.
110	Western Highlands	**DMA contract, p. 69 – 1st paragraph - Attachment M- Statistical Reporting Measures**: "DMA will provide guidance to the LME in meeting the statistical and other reporting requirements on this Contract". Does this mean training? FAQ document? Please clarify.-Identify reporting requirements that will be standardized vs. developed in-house by the LME?	The State will provide technical assistance. The State's required performance measures will be standardized.
111	Western Highlands	**DMA contract, p. 69 - Attachment M – Statistical Reporting Measures A. Effectiveness of Care Measures #6**: LME reports via Community Progress Indicators (CPI) and analyzes Medicaid enrollees as a subgroup, sometimes with breakdown by age/sex. These measures, such as follow up to hospitalization, have been coming to us from DMH. Do we now take responsibility for coming up with these calculations? Will DMH still be sending reports for LMEs?	The State will provide technical assistance for getting the data needed for the Community Progress Indicators report. The LME is responsible for reporting all measures in the contracts.

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112	Western Highlands	**DMA contract, p. 81 - Attachment P-Network Provider Enrollment and Re-Enrollment**: Reference here to "…LME Provider Quality Performance System with ratings of Routine, Preferred, Exceptional and Gold Star..." Does this mean we will be adopting PBH's "report card" system?	The LME must submit as part of their application how they will perform this function.
113	Western Highlands	**DMA contract, p. 95 – Attachment V – Mixed Services Payment Protocol**: is there any data to give an indication of what procedures on pp. 95-96 incur and get reported in a year by hospitals – averages, typical cost/customer? Can DMA provide this data to the "waivered" LMEs for SFY2009 for reference?	Yes. We will provide it to the selected LME(s).
114	Sandhills	**DMA contract, p. 31, Item 7.6 Credentialing**: "The LME shall adopt and implement written policies and procedures governing the qualification, credentialing, re-credentialing, accreditation, re-accreditation… ""The LME shall, at a minimum, consider the following information when deciding whether to re-accredit and re-credential a Network Provider"… In this context, what is meant by "accreditation and re-accreditation"?	"Accreditation" and "re-accreditation" are synonymous with "credentialing" and "re-credentialing" in this context. Since the scope of this process is different than existing LME functions the terms are interchangeable. For example, with outpatient functions, credentialing is more utilized than accreditation
115	Sandhills	**DMA contract, p. 36**: Each of the LME network providers shall have a unique identifier. What is that identifier?	"Unique identifier" refers to a provider number that identifies the individual service provider or service provider organization.
116	Sandhills	**DMA contract, p. 83, Item B., Network Enrollment Requirements for Agency Based Providers**: # 18 and # 19 Is the LME responsible for the credentialing of individual providers within the agency or rather, reviewing the agency to assess provider agency compliance?	The LME waiver entity is responsible for the credentialing of and reviewing the agency based providers and staff for the services for which are being contracted to provide and ensuring on-going compliance. The RFA states that following the selection process and the announcement of the next LME(s) to participate in the waiver expansion process, the new entity will work with DMA, DMH/DD/SAS and PBH to collaborate and develop basic state wide

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			guidelines and requirements.
117	Sandhills	**DMA contract, p. 97**: Can we have more information on required reports to include instructions and sample reports with numbers?	DMA will provide guidance on specific reporting requirements to the LME(s) selected for waiver participation.
118	Mecklenburg	**DMA contract, Part IV: Program Operations, Marketing, Details, Scope of Marketing**: p. 50 • Need the definitions for direct and indirect marketing as the state describes them. • Need a definition of mechanism, "The State will have a mechanism in place to help enrollees…" • How often does a consumer/enrollee handbook need to be distributed—upon enrollment and then annually? • Are we required to have a fully translated Spanish version of the Handbook available and ready to submit with the application? • Need to know what "shall provide each new enrollee, within 14 days, written information on the Medicaid waiver program," means. What written information? Is this information that would/should be contained within the consumer handbook or is it a separate doc in the enrollment packet?	As stated in the waiver amendment, marketing, both direct and indirect, are not applicable as only one PIHP per service area will be selected and enrollment is mandatory. "Mechanism" means written policies and procedures. See section 6.11 of the DMA contract regarding consumer information requirements and Spanish language requirements.
119	Mecklenburg	**DMA contract, Section C: Enrollment and Disenrollment, Details**: • p. 56, Outreach o How is "special populations" defined? o Is an additional toll free number dedicated for the "capitated members group" required? Or, will all calls be routed via our existing tool free number. • P. 59, Disenrollment o Do we describe the "good cause reasons for which an enrollee may request disenrollment during the lock-in period…" in the Handbook?	Refers to the waiver for special needs populations. Specific parameters for each special population are being developed. The LME must define how this will occur regarding toll free numbers. See sections 4.6 and 4.7 of the DMA contract regarding reasons for disenrollment.

#	Source	Question & Reference	Answer
120	LME Source Unknown	**DMA contract, Staffing**: p. 20 - Can a bachelor's level LPC or LCSW fulfill the role of UM?	No.
121	ECBH	**DMA contract, Minimum Requirements in Section 9, p. 3**: Third Party Coordination is mentioned as one of the requirements. Does this mean the LME is expected to bill the third party for the contracted providers or that the providers are submitting to the OLME what they have previously billed to third party insurance?	Medicaid capitated payments have been adjusted to account for third party payments. Third party billing arrangements are the responsibility of the LME. The LME should indicate in its response to the RFA how it proposes to handle third party payments and coordination of benefits.
122	Center Point	**DMA contract, Reporting Requirements** What type of technical IS support can be provided to start in reporting requirements.	None.
123	Center Point	**DMA contract, Reporting Requirements**: When will report specifications detail and other information about information exchange be made available?	Reporting measures are specified in the DMA contract. Attachment M lists some of the required reporting measures. PIHPs are also responsible for ad hoc reports as requested. DHHS will provide guidance on specific reporting requirements to the LME(s) selected for waiver participation.
124	Center Point	**DMA contract, Reporting requirements**: Will existing VO or PBH reporting requirements transfer to the PIHP reporting requirements? Will these be decided by the State or will selected vendor have an opportunity partner with the State to develop?	Reporting measures are specified in the DMA contract. Attachment M lists some of the required reporting measures. PIHPs are also responsible for ad hoc reports as requested. DHHS will provide guidance on specific reporting requirements to the LME(s) selected for waiver participation. (See above comments on standardization among PIHPs—this includes collaboration with the State). The RFA states that following the selection process and the announcement of the next LME(s) to participate in the waiver expansion process, the new entity will work with DMA, DMH/DD/SAS and PBH to collaborate and develop basic state wide guidelines and requirements also noting that some Quality Management Performance Requirements are subject to change.

#	Source	Question & Reference	Answer
125	Center Point	**DMA contract, Special needs populations**: Define special needs for high risk / high cost populations (HRHC).	Page 22-23 (Section 6.13) define specific populations under "individuals with special health care needs" and also outline the LME PIHPs responsibility to these identified populations.
126	Center Point	**Covered populations**: How do you get eligibility information?	As part of the RFA application the waiver entity is required to have policies and procedures in place describing how they will facilitate the exchange of such information.
127	Center Point	**DMA contract, Customer Services**: Define Customer service staff.	Section 6.7 of the DMA contract outlines the duties of the Customer Service staff. The PIHP must detail in their application, their plan for meeting these needs, including staffing patterns.
128	LME Source Unknown	**DMA contract, p. 83**: #19 "A minimum score of 85% must be achieved on the LME qualification … "	Any agency based provider seeking enrollment per the DMA contract with a LME Waiver Entity must meet pre-defined requirements. The RFA states that following the selection process and the announcement of the next LME(s) to participate in the waiver expansion process, the new entity will work with DMA, DMH/DD/SAS and PBH to collaborate and develop basic state wide guidelines and requirements.

Questions about the DMHDDSAS Draft Contract

#	Source	Questions & Reference	Answer
129	ECBH	**DMHDDSAS contract, 6.4 Access to State Operated Facilities**: Requirement states that "LME Director shall serve as designee….in approving admission to the State psychiatric hospitals…" Does this mean that the LME Director must hold clinical licensure?	The LME Director must adhere to NCGS requirements of 122C-121. This does not require clinical license. The phrase refers to administrative responsibility serving as a designee of the DMHDDSAS Director and the LME agency has in finding appropriate alternative treatment arrangements within the community prior to approving a state hospital admissions.

#	Source	Questions & Reference	Answer
130	ECBH	**DMHDDSAS contract, Staffing**: Can the LME Director requirement in the DMHDDSAS contract be satisfied by the UR Director?	The LME is responsible for proposing to the State, in the submitted application, how it will propose and carry out the required functions described in the RFA and both the DMA / DMHDDSAS contracts. The organizational structure of the LME should be outlined in the proposal. State Statute requires the LME to have a Director who meets certain specific qualifications.
131	ECBH	**DMHDDSAS contract, Attachment III Financing, 1.4 Administrative Limits**: The draft contract states "The following limits apply to funding for LME administrative activities. The LME may take a 9.5% administrative fee from its state and federal allocation ….The LME is responsible for covering administrative cost related to management of state and federal services within the 9.5% administrative fee." Does this mean the LME takes the 9.5% of our single stream and federal allocation in lieu of our current funding for LME cost under the current LME cost model? Does the cost model no longer apply to waiver sites? We understand that 9.5% administrative fee is not necessarily the administrative fee that will be paid per the capitation rate setting.	Yes. See footnote on page 34 of DMHDDSAS contract that says the 9.5% administrative fee is subject to change. The LME is responsible for covering the administrative costs. The cost model will not apply to the waiver LME. The administrative fee is a part of the capitation rate setting and State funding. See response to question 17.
132	Western Highlands	**DMHDDSAS contract, p. 35 – 1.4 Administrative Limits**: refers to LME administrative activities for a 9.5% administrative fee from state and federal allocation. Please define what is included in "LME Administrative Activities" vs. "Waiver System Management". Which functions under 1.0 does this cover? What is the formula regarding administrative functions for IPRS consumers, formerly calculated using the "LME Cost Model"?	The LME's administrative activities include the functions on page 3 under the Scope of Work of the DMHDDSAS Draft Contract and Section 1.0. The formula is the 9.5% of the State funds paid as PMPM. See Attachment III related to Finance, footnote comment, finance section subject to change.